# Coordinated Chronic Disease Prevention and Health Promotion: Old Dilemmas, New Horizons

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### **Overview:**

- A unique public health lens
- Why our work together is so important
- New opportunities & new horizons in the current environment

### Imagine a World .....



#### **Achieving Healthy States: The Power of WE...**

- Public Health
- Schools
- YMCA's
- Non profit organizations
- Businesses
- Hospitals
- Elected officials
- School superintendents
- Mayors
- Tribal leaders
- Local aging centers/senior centers

- Recreation and Park Departments
- State Health Departments
- City Planners
- Redevelopment agencies
- Transportation agencies
- Faith based organizations
- Philanthropic leaders
- Community leaders
- Health Plans
- Foundations
- Many more.....

# Why strategies to create healthy states (PSE)?

#### Institute of Medicine

"It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change. If successful programs are to be developed...attention must be given not only to the behavior of individuals, but also to the environmental context within which people live..."

-- Smedley and Syme, 2000

### **Evolving frameworks: the past**



Individually-oriented, program driven approach

### **Evolving frameworks: the present**

Institute systematic changes to the physical and social environment related to chronic disease risk factors



### **Factors that Affect Health**

Smallest Impact

Counseling & Education

Clinical Interventions

Long-lasting Protective Interventions

Changing the Context to make individuals' default decisions healthy

**Socioeconomic Factors** 

#### Examples

Eat healthy, be physically active

Rx for high blood pressure, high cholesterol, diabetes

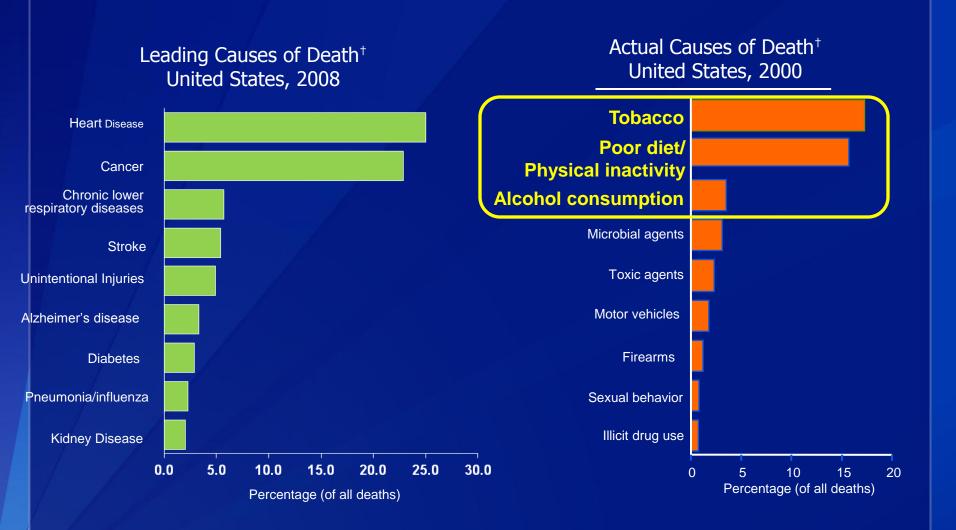
Immunizations, brief intervention, cessation treatment, colonoscopy

Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax

Poverty, education, housing, inequality

Largest Impact

#### **Chronic Diseases and Related Risk Factors**



<sup>\*</sup> Minino AM, Murphy SL, Xu J, Kochanek KD. Deaths: Final data for 2008. National vital statistics reports; vol 59 no 10. Hyattsville, MD: National Center for Health Statistics. 2011.

<sup>†</sup> Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

### Disabilities

- Arthritis is the number one cause of disability.
- Stroke has left 1 million
   Americans with disabilities.
- Heart Disease the leading cause of premature, permanent disability in the U.S. workforce
- Diabetes the leading cause of kidney failure and new blindness in adults.



### **Alarming Health Disparities**

- Heart disease death rates 30% higher for African-Americans than whites; stroke death rates 41% higher
- Diabetes higher among American Indians and Alaska Natives (2.3 times), African Americans (1.6 times), and Hispanics (1.5 times)
- About 30% of Hispanics and 20% of African Americans lack a usual source of health care compared with less than 16% of whites

### Rising Obesity in Children Prompts Call to Action

#### **Overweight? It Depends**

Adults with a body mass index of 25 or higher are considered overweight. In children and adolescents, however, body fat changes from year to year, and acceptable levels differ in boys and girls. To determine (HEIGHT IN INCHES) x (HEIGHT IN INCHES)

COMPUTING THE BODY MASS INDEX\*

weight status, a child's bo status is based on these e

with a body mass

### Social Security, Medicare systems facing possible crisis as baby boomers grow old

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#### **CHANGES IN U.S. POPULATION'S** AGES, 1990-2000

The number of U.S. residents ages 45 to 54 increased pearly 50 percent

37.6%

19.9% 13.5% 4.5%

Source: U.S. Census Bur

#### For Medicine, a Growing Problem

Doctors, Hospitals, ERs Struggle to Handle Wave of Obese Patients

pecial to The Washington Post On a chilly October day a few years ago, a 44-year-old woman lay in the internal medicine ward at Georgetown University Hospital. Pockets of infection vere breaking through the skin on her abdrip of powerful antibiotics for her chronic non-healing wounds. I was a third-year medical student, and she was now my patient. After reviewing her medical history, I vent to order a magnetic resonance image (MRI) to give me more information.

> I explained the situation to my superi ors and asked for advice. Their answer startled me: Call the National Zoo and schedule a session with the zoo's MRI.

patient was too big to fit inside.

for my patient. I wasn't sure I should take this instruction seriously. And if so, how was I supposed to tell my patient she might have to wait in line behind an ele phant or a panda for her turn at the MRI

No room for the obese-to a lot of heavy Americans, that seems to be a slogan for the entire American health care system. And this is no minor issue: Ac cording to the National Institutes of Health, nearly two-thirds of the pop



obese," with a body mass index,

premature death. to the doctor more often than others, but in many cases they are not. Studies sugest this is because they believe the nealth system doesn't want to deal with

that are too small; waiting room chairs they cannot squeeze into; scales placed in public view; exam tables that tip over procedures (such as pelvic exams) that turn embarrassing when extra staff is re

quired to lift the patient's middle. And always there is The Lecture: be ing told, repeatedly, that "all you need to do is lose weight, and only then can we get a handle on your other health issues.

Hally Mahler, a public health expert specializing in HIV and AIDS, remem bers getting The Lecture for the first time when she was 8. "He would say to me, 'You're getting too fat, you have to lose weight, it's now or never.' It was em barrassing. It became embarrassing go

ing to the doctor."

Today Mahler is 35 and still big. But that childhood memory lingers. "As a child it was terrible, I resisted it, I did not want to go to the doctor, ever," she says. Even as an adult, she has found med-

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### **Things CAN Be Different!**









### From the time a person wakes up



#### Maximizing public health impact in states

**Impact** ≡ Reach **\*** Exposure **\*** Potency

Focus on changing things that affect many people with frequent exposure

in a comprehensive way

### **Maximizing public health impact**

50% healthy vending slots



Ban on unhealthy foods in cafeteria



Whole school reform



Schools + healthy corner stores

Walk to school day



Walk to school year



**Safe Routes to School** 



Safe Routes to School + Complete Streets

### Part of a grand history (i.e. – nothing new ...)

- Water potability
- Vaccination requirements to enter school
- Food safety inspections
- Fortification of the food supply
- Shatter-proof windshield requirements
- Bicycle and motorcycle helmet law
- School lunch programs
- Increased cancer screening by adding mammography coverage to state employees insurance
- Interest deduction to increase home ownership

### **New Challenges; New Opportunities**



The tight fiscal environment is straining budgets and causing uncertainty about the future



Health care reform is creating opportunities for greater collaboration



Public health science supports population-based approaches as best way to broaden impact

### How we got here: historical context

- Growth of chronic disease prevention efforts at CDC; categorical appropriations (reflects public)
- 2008 Negotiated States Pilot Agreement
- Early small steps at CDC to enhance coordination
- OMB and Congress look at consolidation as an option (Senate 2011 budget combined 5 chronic disease budget lines into a single grant program; FY 2012 President's Budget combined 8 lines; FY 2013 budget again calls for consolidation)
- \$42 million to CDC in FY 2011 to launch coordinated chronic disease efforts – awarded to states
- CDC looks at a variety of models for coordination

### CDC's Response: New Horizons in Chronic Disease Prevention

### Take Stock:

- Need for seamless and efficient system of support to states
- Reduce administrative burden to states
- Identify opportunities for flexibility
- Increase coordination
- Permission to think differently about how we organize our work

### CDC's Response: New Horizons in Chronic Disease Prevention

### Step Up:

- Strong base in every state
- Leverage shared basic services; expand the reach of categorical dollars
- Shift the health of populations with high risk
   & burden / multiple chronic conditions.
- Systems approach power of "we" improves the health of entire populations

### CDC's Response: Coordinated Chronic Disease Prevention

- Ensure that every state has a strong foundation for chronic disease prevention & control
- Maximize the reach of states' categorical CD programs by leveraging shared services
- Provide leadership to work collaboratively across diseases and risk factors
- Improve how CDC works with states

### Responding to the Needs of this Era



seamless, efficient, reduce administrative burden, flexibility, coordination, do our work differently

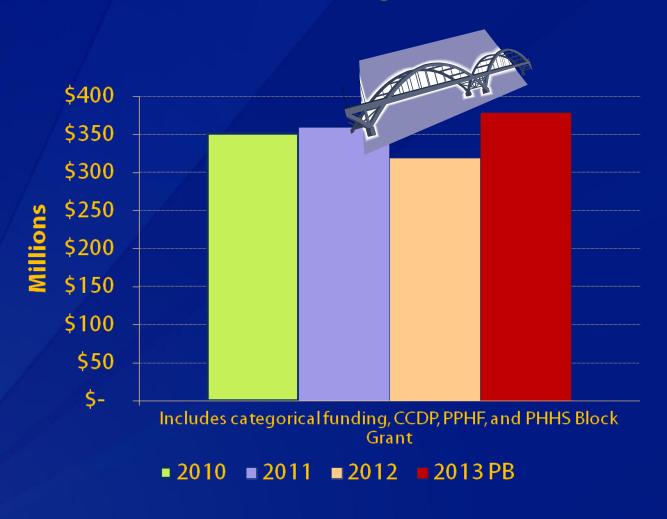


strong base in every state, leverage shared services to expand reach, systems approach



impact entire populations, shift the future health of people with high burden

### Opportunities and Challenges: Budget FY 2012 (Yr 2) - "Bridge to the Future"



### **What States Are Doing**

- I. Develop a state chronic disease plan & engage statewide partners plan should:
- •be driven through collaboration with a broad range of statewide partners, including non traditional partners
- engage all major categorical programs at the state health department, including key categorical partners
- •include analysis and identification of priority "big steps" that can affect multiple conditions of interest to multiple partners

### **What States Are Doing**

### II. Create a management plan for leadership inCD prevention – plan should address:

- Leadership
- Organizational design
- Communication
- Capacity to achieve changes in 4 key domains
- Capacity to provide TA to communities

### **What States Are Doing**

III. Build capacity and achieve changes in 4 key domains

> **HEALTH SYSTEMS** CHANGE

COMMUNITY-CLINICAL LINKAGES

**EPIDEMIOLOGY** 

**EVIDENCE-BASED** PRACTICE & APPROACHES

### Program Expectations: Emerging Practices in 8 Component Areas

- State HIth Dept Practices & Capacities (Internal)
  - Program Management and Leadership
  - Organizational Structure
  - Capacity in 4 Domains
- Collaboration, Engagement, Communication (External)
  - Chronic Disease Prevention and Health Promotion State Plan
  - Collaborative Process
  - Communication Plan
- Data & Information for Decision-Making
  - Surveillance and Epidemiology for Chronic Disease
  - Evaluation

### What CDC is Doing: The Coordinated Effort at CDC

- Coordinated approach to support for states
  - Technical assistance, training, consultation, state teams, organizing training support differently
- Opportunities for efficiencies in how we put \$
   out the door and how we manage those \$
  - Common language in FOAs, consistency in management information systems, reduce administrative burden, etc.
- Core strategies in 4 key domains
  - Shared vision and understanding across programs; linked with Chronic Disease State Plans

# Domain 1: Epidemiology and Surveillance - gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health

- Surveillance of behavioral risk factors, social determinants, environmental changes
- Collect cancer surveillance data to assess burden and trends
- Surveillance of tobacco-related knowledge, attitudes, and behaviors

Domain 2: Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, communities)

- Nutrition standards for food and beverages offered in specific settings
- Increase the amount of daily, quality physical education in schools
- Comprehensive smoke-free air policies

### Domain 3: Health systems interventions

- Delivery of high-quality screening for breast, cervical, and colorectal cancers
- Organized system of care to deliver highquality clinical preventive services
- Health care information systems with automated physician prompts & patient reminders for screening / referral
- Quality improvement of clinical care for control of A1C, blood pressure, BMI, cholesterol, cancer screening

### **Domain 4: Community-clinic linkages**

- Available, accessible arthritis, diabetes, chronic disease self-management education programs, including physical activity programs, to reach at-risk pop's
- Use of allied health professionals to enhance management of high blood pressure/cholesterol, A1C
- Effective outreach to the population to increase use of clinical preventive services

# Where do we hope this approach will take us?

### State Health Department of the Future

- Highly skilled chronic disease staff in every state
- Strong surveillance data documenting the burden and reach of the categorical programs
- Robust evaluation capacity
- Informed policy makers who understand the burden of chronic disease and the need to scale up effective interventions
- State residents who understand and support the need to address chronic disease
- Efforts to address heart disease, diabetes, cancer, nutrition, physical activity, arthritis are accelerating

### Outcomes: What is happing in the state?

- Major changes are occurring in
  - Environmental factors
  - Health systems changes
  - Clinic-community linkages
  - Significant, ongoing, and systematic surveillance & epidemiology activity is positioned to support achieving these changes

### Do We Want This World?



### Things CAN be different!



### The Power of "We"

